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ABSTRACT

This newsletter theme issue looks at infant day care models including those emphasizing early intervention with special needs infants. The lead article, "Infants in Day Care: Reflections on Experiences, Expectations and Relationships," by Jeree H. Pawl, stresses the importance of understanding infants' and toddlers' capacities and needs in designing day care services. Three brief essays were adapted from a December, 1989 seminar and describe three distinct but related models for incorporating infant mental health insights and strategies into day care for young children. Titles and authors are: "Mental Health Consultation to Day Care Providers: The San Francisco Daycare Consultants Program" (Kadija Johnston); "Promoting and Safeguarding Early Relationships in Child Care: The Child Care Dallas Family Day Home System" (Sonya Bemporad); and "An Infant Mental Health Training Model for Day Care Professionals: The C. M. Hincks Institute National Day Care Training Project" (Elisabeth Muir and Elizabeth Tuters). Remaining articles include: "Models of Integration Through Early Intervention/Child Care Collaborations" (Mary Beth Bruder, Penny Deiner, and Sandy Sachs); "Outreach to Family Day Care: A National Volunteer Initiative" (Matia Finn-Stevenson and Pat Ward); "NICHD Infant Child-Care Network: The National Study of Young Children's Lives" (Sarah L. Friedman); and "Whole Babies, Parents and Pieces of Funds: Creating Comprehensive Programs for Infants and Toddlers" (Peggy Daly Pizzo). (DB)

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[Infants in Day Care]

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Infants in Day Care: Reflections on Experiences, Expectations and Relationships

by
Jeree H. Pawl, Ph.D.

Day care, as an important experience for very young children, cannot be separated from our continued attempts to appreciate and understand relationships in general. Day care must be thought about and seen as occurring in a context of other relationships and as containing relationships.

When "relationship" is highlighted and articulated as the true issue for children, parents and caregivers, the understanding of what day care is shifts. It is only when *relationships* are recognized as the major issue that changes in the quality of care can happen that will make the day care of children more appropriate.

Understanding the experience of infants in day care does not, as it sometimes seems to, primarily involve an understanding of issues of separation. In fact, that focus as the major issue of concern may be far more central to the experience of the parent than it is to the experience of the child. There is a separation, of course, both as an event in reality and as a psychological process, but it all happens in a context—to very differently functioning children, with very different relationships with their parents and in very different day care circumstances. In addition, children in general have varying experiences with separation from major parental caregivers in situations other than day care.

We have expectations regarding the tolerances of infants and toddlers for separations, that reflect parental needs and cultural styles. These expectations are not necessarily either natural or unnatural in some absolute sense. They are there. American babies for example, are known to nap alone and even sleep alone all night. Often too, mothers disappear when they lean over to tuck in the bedding and they're out of the line of sight of their infants who then may howl or may not howl. Mothers also go to the bathroom (though

in my experience less frequently alone than they would like) and mothers may even go shopping while someone else cares for their sick child or just because they want to go shopping alone or with a friend and sometimes all day. In this culture—that is the way it is. On the other hand, surely no caveman or cavewoman ever sought a small cave next to theirs in which to place their infant at night. Sleeping with infants is probably evolutionally "natural" or at least has a very long

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history. More of the world does it than does not. It behooves one, then, to think very carefully about where we draw lines on what is clearly a continuum and to pay attention to why we are deciding that X is ok but Y is not.

The real task is to try to understand as much about infants' and toddlers' capacities and needs as we can and then to apply that to our understanding of children's experience and particularly to the individual child's experience, and that includes "day care."

First of all, of course, the phrase "day care" itself subsumes a wide range of caregiving arrangements for children. Licensed center and licensed family day care are in the minority—representing a far lower percentage of out-of-home care than other arrangements.

The real task is to try to understand as much about infants and toddlers as we can, and then to apply our understanding to the individual child's experience, including the experience of "day care."

More frequent arrangements include a neighbor who keeps several children, an unlicensed home where numbers of children are cared for, or a private arrangement with a friend or relative. It is interesting that in many of these latter arrangements concerns about separation and about the evils or virtues of day care barely arise. The same person who might deride center care may cheerfully drop her own child off with her mother each morning or have had three au pairs in her home in 14 months. Clearly, the *fact* of separation is not the issue for this woman; although arrangements which result in her not feeling guilty about her child's care may be her concern. So separation per se is only a part of a far larger and more important issue.

I have seen more than one child left in the care of a grandmother so incapacitated that the care was literally dangerous. I have seen mothers leave their infants with relatives whom they dislike and distrust and by whom they have felt ill-treated both currently and in the past. The virtues of this for the children were certainly limited, though quite real. They were with someone who had an ongoing meaning in their life, who may have conveyed her special investment in some way, and who would continue to be an important figure. Though even here, situations are very complex.

Recently, a young woman was referred to us after calling a Talk Line out of fear that she would injure her 19-month-old child. He was, she said, horribly aggressive and had been totally impossible from birth. In fact, what we learned was that since his birth, Jose had been left all day, 5 days a week with his parental grandmother while his mother worked, and that this grandmother had gone back to Nicaragua three months before. Joe's day care situation had shifted to a neighbor who had 6 children in her sole care and whom the mother herself described as rough and volatile.

It took time for this mother to appreciate the meaning of any of this. It took time to help this mother experience that her son's loss of his grandmother and subsequent inappropriate care arrangement were the major sources of Jose's very difficult behavior. She was able to

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NANCY P. ALEXANDER

remember that he had, in fact, not been "aggressive and impossible from birth." Their difficulty is resolving very nicely in the context of our program's weekly visits and a better day care situation.

In fact, this child had lost not only one major caregiver but had also effectively lost another—his mother. Because of her lack of understanding and her angry response to his expressions of grief, she was not available to him in any familiar reassuring way. His grief and despair burdened and angered her, and she rejected and punished him. When the mother was able to understand her son's experience, the problem for them both began to resolve, even though the loss of his grandmother's care remained a real loss to Jose. Jose is deeply attached to his mother, and with her restoration to him, he is functioning quite well. An appropriate day care experience is also salient to his good functioning. After the loss of his grandmother, his need for a day care environment which could be truly responsive to him was even more vital to his well-being.

Sometimes it may feel to parents that they have somehow abandoned their child when they have left their child in a day care center or professional family day care home, but that they have not abandoned that child when he is left with a grumpy and almost wholly incapacitated great aunt. The assumption that care is all right because of consanguinity is about as sensible as assuming that biological parenthood automatically assures sensitive and thoughtful childrearing. And this is illuminating. In either case the care may or may not be adequate. It may be only that the parent will feel less guilty in one situation. This is certainly not unimportant; guiltlessness will have it own effect on the parent-child relationship. But what assuages the discomfort may be irrational.

What is it, in fact, that might make a parent feel more comfortable? Without a clear awareness of why it might really matter, the parent may feel comfortable in leaving a child when the child has a relationship with someone—a grandmother, a neighbor, or a friend.

There may be an unarticulated recognition of the importance of relationships even though in much of what any parent would read or hear, "separation" is often more discussed as an issue. In fact, in situations where a child is cared for by a neighbor, friend or relative, not only the child but the parent has a relationship with that caregiver. The parent really *knows* who that person is and therefore has some faith, misplaced or not, in the appropriateness of the child's care. The same is often true of care provided in the child's home where the "sitter" becomes known to the parent as the two casually exchange daily information of all kinds.

This continuity for the parent, this reassurance, is often missing, though it need not be, in other kinds

of care. In centers or other non-relational care, caregivers tend to be pressed for time, as is the parent, and sometimes out of discomfort the parent behaves as if there were a sharp division between two worlds and she simply leaves her child with an uneasy faith that he will be all right. She does not think, because it may seem irrelevant in these circumstances, of the "relationship" of her child to the adults or of her own to them; she only hopes that he is safe, fed and won't cry too much. Relationships between people are not necessarily conceptualized as the centrally important factor in day care, and the various continuities which are based on the adult relationship are often insufficiently appreciated.

As Sibylle Escalona assured us, infants can be relied upon to put together the available nutriments from their environments. The infant whose primary substitute caregiver is truly available for a responsive, respectful relationship or the infant who has several primary caregivers over the course of a long day—all of whom are appropriately available, has the opportunity to form some meaningful relationships. We would, of course, wish to limit the number of individuals to whom an infant must relate, and relate is the operant word. We want the experiences of the infant or toddler to be predictable and familiar, and the interaction to have within it those elements which allow the infant to experience her needs as recognized and responded to appropriately.

The infant whose primary caregiver is truly available for a responsive, respectful relationship—or the infant who has several appropriately available primary caregivers over the course of a day—has the opportunity to form some meaningful relationships.

Such responsivity cannot be a consistent feature of a child's experience in a truly satisfying way if one person feeds, another diapers, another rocks and another sings songs. That degree of fragmentation creates relationships which are undoubtedly too shallow and too abbreviated. However, even if several people do all of these different things during certain serial time periods, a child is probably capable of establishing a sense of mutuality and effectiveness, and that is the major crucial and important factor. In these circumstances, infants will establish their own hierarchies of preferences, both between people in a general way and between people in specific ways. They certainly do this in family relationships. In the mood for hi-jinks? That's Uncle Bob's forte. Stomach ache? Mother handles that well. And Daddy is terrific at wandering around pointing at environmental adventures—like wiggly worms, airplanes, and dogs digging up the front lawn; besides, he has that specially silly sound he makes before he snuggles you in the tummy.

We allow and expect these predilections of infants and toddlers in the ordinary course of events, and they do not worry us at all. So too, the primary substitute caregiver will have her strengths, as will the parent. Overall, however, if there are no serious impediments to the parent-child relationship a parent has far more than an edge. There is no question that by and large the parent's investment in the child—his or her claiming of the child—is transmitted in unmistakable ways. No one else is so likely to make the child feel as good about herself, as special, as important or as valued. This unique sense of well-being and self worth guarantees a powerful reciprocal response toward the person who generates that experience. And this person exists in the familiar surround of things and space and people that is where you come from and return to. There has never seemed any reason at all to worry that responsive parents will not matter most to a child.

So what are we worried about when small children are in day care? We think about their moment-to-moment experience. We do not want a child to feel lost or abandoned or to yearn painfully and endlessly for us and be helpless to fix things. This probably means, then, that separation experiences need to be titrated so as to become tolerable. It is not a good idea to be almost always available to a child and then suddenly leave him for 8 hours, 5 days a week, whether at 3 months or at two years. Over time, and in doses, the child must be given the opportunity to establish a relationship with the person with whom he is to be left.

And here we get to the issue of individual differences, as well as previous experiences. Some children find relative strangers quite upsetting, especially when they abruptly assume roles other than that of stranger. As we know, certain children will approach after awhile, and others will take a very long time. Some children can tolerate a quiet, non-intrusive presence whom they are free to engage or not, but they will howl with anguish if someone dec[illegible] to approach them. But the parameters of the category "stranger" are very different for different children. Such differences are not in any simple way connected to a child's age. Some two-year-olds are as wary as some 9-month-olds. And some 9-month-olds are as sanguine as an experienced, outgoing three-year old. Certain two-year-olds have almost zero tolerance for the absence of their mothers, while certain 9-month-olds adjust very rapidly. These varying tolerances reflect the temperament of the child, the quality of primary relationships, the child's experience with separation and the meaning of separation; even then this is all a complex transactional phenomenon with each of these things affecting the other.

One of the issues around separation is the issue of whether or not infants "remember" their parents—or what they experience in regard to them while separated. We know from Leon Yarrow's very early work that infants recognize a change in caregivers within at least weeks. We also know that infants and toddlers remember their parents when they are separated from them. If a five-month-old can remember and demonstrate to us that she felt negatively or positively about

one of two puppets which she encountered for 10 minutes one week before, then *we* are not likely to be forgotten. We don't need to wrestle with the differences between recognitive and evocative memory. The recognition of a familiar person and ability to call the person to mind in her absence are actually on a continuum; both are dependent on the child's experiencing certain cues associated with the person. In any situation, there will be sufficient internal and external cues to evoke memories of us in our absence. The cuing is subtle but very evocative. It *is* questionable, however, whether and when there is enough organized sense of our constancy and eventual reappearance to reassure and quiet the child's occasional yearning for us. Children may be soothed and comforted by others in their need for us to respond to all kinds of things—hunger, reassurance, play and attention—but will their need just to *see* us be totally assuaged? Probably not. So it matters even more that the care available at the moment does not leave the child feeling abandoned (This is equally true even when a child is old enough to know that we will come at 4 o'clock.)

It's clear that affective memories as well as cognitive memories are encoded. The affective memories are encoded long before language. It is not clear *how*, but the evidence is overwhelming that they are. The internal models of relationships—what they promise and how they work—are gradually organized around specific, discriminated people—mothers and fathers and siblings and aunts and caregivers. Which aspects of these relationship experiences will be triggered by what later encounters is undoubtedly very complex. But we are certainly safest in trying to ensure a basic optimistic core to all of these early relationships where we can do so. Most vital, it seems to me, is that the infant or toddler is cared for in ways that promote his feeling effective, respected and understood much of the time. The sense of having needs met—the sense that relationships hold promise—will hinge not only on parental input into the child's experience of safety and trust; it will develop as well within relationships with others. If this occurs both with parents and with caregivers, then we have far less about which we must be concerned.

Most vital is that the infant or toddler is cared for in ways that promote his feeling effective, respected and understood.

In addition to concerns about the child's experience in the moment, and mastery of separation, many of us have other concerns. What effect will early experiences in day care have on the quality of relationships which the child will be capable of in the future? Will the child have affective, unverbalized memories of abandonment and helplessness, and have poor trust in relationships? Are children monotropic—needing one kind of nurturance involving a single constant caregiver—and will they be damaged if this cannot be totally accommodated? We wonder whether, without this, a child will be capable of deep, abiding relationships characterized by intimacy.

In fact, these long-term issues can best be addressed by understanding and addressing short-term issues. Where care is taken to assure safe, tolerable and rewarding relationship experiences in the present, we are doing the best we can to protect relationships in the future. To be able to assess the effects of day care on a particular child, then, a parent must acknowledge—really know—that she or he is leaving the child with a particular person or set of people; the parent will have to notice what the child's relationship with that caregiver is likely to be. I am sure all of us know how unbearable that is for many parents who have no good choices; if they looked and understood, they would find the reality intolerable.

Parents who have no good child care choices may find it unbearable to look at and understand the reality of their child's relationship with her caregiver.

Perhaps it is now time to ask if we, as a society, indeed wish our children to be capable of deep, abiding intimate relationships. I believe our answer would be a resounding "yes," but we might wonder if intimacy is in fact a valued quality in the majority of personal relationships these days. If intimacy is *not* part of a person's life, does its absence represent "freedom"? Are we as a society experiencing a re-evaluation of human relationships? How do we approach the transmission of cultural values in the midst of massive cultural change? It is difficult to think about, for it, too, is a transactional, almost circular phenomenon. Our habitual linear, unidirectional thinking fails us when we try to decide if our society is *creating* a problem with intimacy and separation or whether individual problems with intimacy and separation are creating a societal tolerance, if not a need, for major cultural shifts.

We can expect that parents who are forced to rely on day care for their infants or whose internal dynamics more comfortably fit with shared care will have led the way, while others strain and possibly break under the demand to place their children in substitute care. We can argue that the demand to place infants in day care will be met increasingly easily by the children of the children whom we are creating, as they will have no difficulty tolerating separation and attenuated intimacy. Or we might argue that with awareness and care we can create children who will balance the demands for separation with sufficiently healthy relationships to adapt without great personal cost both to what society now demands and what it yet still treasures.

We must recognize that in addition to pressures on parents of infants to remain in the work force, there are other cultural demands for mobility, geographical

distance between nuclear and extended family members, and lengthy separations of infants and toddlers from their parents. It may be a three-year separation for little George, between the ages of 2-5; he is with Aunt Franny in Miami because his single mother in San Francisco can cope with her 7-year-old and her baby but not with him. Life for Jimmy consists of four days each week with mother and three with dad, now that he's two; his parents were separated before his birth. There are desperate immigrants who leave children behind for years and then reclaim them. This family of five has moved three times in three years in pursuit of work promotions. Clearly these phenomena are both causes and effects. Some people seem to adapt with apparent ease to experiences which others might feel as alienation from close human ties. I think we must come to grips with the basic questions we are really asking and be hard-headed in our responses.

In a world filled with massive separations and losses, the issue of separation in day care is of minimalist concern. Yet if we can think well about this issue, we may find paths to addressing larger social concerns.

As parents, we can allow our child in day care to miss us, but she should not miss herself.

We could probably all agree that in our society one must be dependent, independent and interdependent to get the best of what may be gotten. We ought not feel that we can simply take or leave particular people, but we must feel that we can function for greater or lesser periods of time both with them and without them—enjoying the reality of all of those states. We can only do this if relationships are inside of us in good and nurturing ways. It is that positive internalization of mutually respectful and contingent relationships that makes flexibility possible. I have written this essay alone, but I could really master doing so because I am alone in the presence of someone. My mother, my father and other important relationships are embedded in my sense of myself in relation to a world of mutually interacting people whom I basically trust and with whom I feel secure.

For infants in day care, their world of mutually interacting people includes their day care providers. These caregivers make their own important contributions to what infants and toddlers come to expect of relationships and how they experience themselves. Only if that care is responsive, understanding, loving and contingent will a child's sense of his central importance, competence, effectiveness, and trust and safety be maintained.

In effect, as parents we can allow our child in day care to miss us, but she should not miss herself. Her sense of herself, and of herself in relation to others should not be damaged. That is the major loss in being separated from a good and adequate parent. Separation itself may be painful in many ways, but it pales in comparison with the child's loss of an effective, competent, well-loved self or a socially competent self who can relate and be related to. There must be relating partners who much of the time respond to a child as he is and in terms of his needs. There must be a sensitive, *caregiving* relationship, not mechanical caretaking.

The child in day care internalizes an important relationship, one that mixes and matches, is concordant with or nonconcordant with relationships with mother, father, siblings, and others. The degree to which these interactions share basic dimensions of respect, responsivity and mutuality is the issue. The 15 minutes shared with Uncle Al cannot compete in the moment, and is a different category of experience from, 8 hours, 5 days a week with Martha, even though Uncle Al may be around for the next 40 years. It is true that Uncle Al will be a part of one's ongoing life, but the Martha or Ann or Bess who cares for an infant or toddler over long periods of time and then disappears will be tucked away inside, shaping the child's expectations and coloring what he imagines relationships can give him and what he can give them. Those expectations should be as hopeful and as promising as we can devise.

In closing, perhaps a quotation from a short story of Tillie Olsen's will convey what the essence is of what I am trying to say about parents, infants, and day care.

"She was a beautiful baby. She blew shining bubbles of sound. She loved motion, loved light, loved color and music and textures. She would lie on the floor in her blue overalls patting the surface so hard in ecstasy her hands and feet would blur. She was a miracle to me, but when she was eight months old I had to leave her daytimes with the woman downstairs to whom she was no miracle at all . . . . Then she was two. Old enough for nursery school they said, and I did not know then what I know now—the fatigue of the long day, and the lacerations of group life in the kinds of nurseries that are only parking places for children."

Tillie Olsen describes what will *not* do. While we must know that not all babies are miracles to their parents, while we must know that no baby is perceived as a miracle all the time by parents, we must also steadfastly insist that each child in day care deserves the highest probability of being perceived as unique, of being appropriately and respectfully interacted with and of having predictable, trusting, mutually determined relationships. By the same token, each parent, and each caregiver, deserves respect, understanding, and support for his or her unique investment in the child. If we can also find ways to help ensure mutually respectful, trusting, and ongoing relationships *between* parents and caregivers then we will have the best kind of shared care for the child.

Day care must not be a "parking place for children" but a viable, rich place for safely learning more about the very complicated but very worthwhile, things in the remarkable world of human relationships.

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Attending to the Emotional Well-being of Children, Families, and Caregivers: Contributions of Infant Mental Health Specialists to Child Care

Editors' note:

The essence of good child care for infants and toddlers lies in the quality of the relationships between and among caregivers, parents and children. It is in the context of these relationships that both the common, basic needs and the unique, individual needs and wishes of very young children are met—or not. It is in the context of these relationships that infants and toddlers continue to develop their expectations about how the world is and how the adults in that world behave. Attachment, intimacy, empathy, separation, autonomy and sense of self and self-worth are major issues in the first three years of life—not only for infants, but for parents and for child care providers as well. Good child care for infants and toddlers builds on adults' awareness and understanding of these issues and their ability, through their relationships with each other and with the children in their care, to encourage their healthy resolution.

Providers, planners, and observers of child care for infants and toddlers have for many years been sensitive to issues of emotional development and well-being in the day care context. As understanding of infant mental health issues has increased, specialists have provided assistance to parents and caregivers around the needs of troubled or difficult individual children. More recently, mental health specialists have explored ways to make day care settings in general more supportive of the emotional well-being of infants, families and caregivers.

The three essays that follow have been adapted from seminar presentations at the December, 1989 National Training Institute of the National Center for Clinical Infant Programs. They describe three distinct but related models for incorporating infant mental health insights and strategies into the practice of day care for very young children. These models include mental health consultation to day care programs; program design and evaluation; and advanced training for day care professionals themselves.

Mental health consultation to day care providers: The San Francisco Daycare Consultants Program

Kadija Johnston, M.S.W.
University of California, San Francisco

Daycare Consultants is a recently established component of the Infant-Parent Program (UCSF) providing case-centered and programmatic consultation to caregivers serving children birth to 5 years of age. While case-centered consultation is necessary and helpful, the effort is intended to have a positive effect on all the children in any day care program with which we are working.

The essence of good care lies in the quality of relationships between caregivers, parents and children. Our appreciation of the power of relationships comes from our experiences as caregivers in both regular and therapeutic day care settings, as consultants to a variety of agencies, and as infant-parent psychotherapists. It is this appreciation that led to our program's conceptualization of what mental health consultation should be.

Mental health consultation, whether it focuses on a particularly difficult child or on an equally distressing but more general program issue, is centered upon and conducted through relationships—those between consultant and consultee, and between adults (parents and caregivers) and children. It is the similarities between these relationships and the parallel processes involved in them, that inform our understanding of how consultation proceeds.

Only by forming a positive relationship with a provider can a consultant truly make available her specific expertise, knowledge and understanding of young children. Just as a child's interest in learning about the world depends on how the information is presented, so the caregiver's interest in exploring new developmental and psychological theories depends on the consultant's ability to create a predictable and protective atmosphere, and to recognize, empathize with and respond to a caregiver's particular concerns. As the caregiver begins to feel that her experience is understood, she will develop trust in the consultant and, eventually, in the consultant's knowledge about children and adult-child interaction.

Consultation aims ultimately at improving the overall quality of care provided to children by increasing caregivers' awareness and understanding of the child's experience. But this aim is realized only as the caregiver comes to appreciate and value the genuine importance of her impact on the children in her care. This is no simple process, especially when the caregiver's relationship is not with one child but with a group of young children, each with unique needs and wishes as well as common developmental needs.

Caregivers often seek mental health consultation for the first time when they are especially worried, alarmed or frustrated by the behavior of a particular child. Even though the eventual goal of consultation is to improve the overall quality of care for all of the children in a particular program, the initial step in the process must be to respond to a caregiver's immediate needs. The consultant strives to learn about the expectations that both the caregiver and child carry into their relationship with one another; to help the caregiver interpret the needs which are being expressed by the child's behavior; and to understand and empathize with the feelings that the child engenders in the caregiver.

Children who are experiencing difficulties, and consequently are difficult to care for, arouse feelings of anxiety, anger and self-blame. As the caregiver begins to feel that the consultant understands and empathizes with these feelings and is not condemning or judgmental, a trusting and mutually respectful relationship can develop. Within this relationship, the consultant's more didactic developmental and mental health information can become useful in shifting the caregiver's perspective about a particular child's difficulties or about broader program issues.

It is important to note that when a particular child is the focus of consultation, we involve the child's parents from the beginning. Information about the child is shared with the consultant only with the parent's knowledge and consent. Observation of the child at the day care setting—with the parent's permission and at the caregiver's convenience—is followed by ongoing consultation to the caregivers and continued contact with the family. The specific ways in which a consultant may prove useful to a particular family are determined by the family's needs and wishes. Initially the consultant may simply help the parents acknowledge and understand that their child is having some difficulties, but the consultant deals with whatever concerns arise—from exploring the effects of the child's past on his present needs, to helping parents with issues of childrearing, to ensuring that parents are engaged with appropriate agencies when longer term help is needed. Her relationship with the child's parents also allows the consultant to put together a picture of the child's background and relationships, in order to help the caregivers better understand the child's current behavior. As the child's behavior becomes more comprehensible, caregivers are better able to respond empathically and with appropriate action.

Two vignettes illustrate our work. In the first, providers who initially request consultation around one troubled child discover that the usefulness of understanding a child's feelings and needs is not limited to a particular case. In the second, program consultation is requested initially and directly.

Cara and her caregivers: Case-centered consultation

The director of an infant/toddler day care center and her staff requested case consultation because of their worries about Cara, a frequently withdrawn and unresponsive toddler. Her worrisome behavior had begun several months earlier when, at one year of age, Cara had been moved from the infant to the toddler room.

One of the first things that the consultant discovered was that despite the fact that Cara's mother visited her child regularly during lunch time, day care staff had discussed Cara's situation with her parents only infrequently. Now, at the very time that Cara's caregivers and parents needed to help each other the most, they remained unfamiliar to, and increasingly suspicious of, each other.

Talks with Mrs. Brown, Cara's mother, confirmed the consultant's hunch that the child's parents shared the caregivers' concerns. Not only were they upset about Cara, but they were further distressed at not being able to share their worries with day care staff.

With the parents' consent and with the mother present for part of the time, the consultant visited the toddler room to observe Cara. She noted the quality of all the interactions in the room-both those involving Cara and her mother and those involving other mothers and toddlers. All the day care staff were kind and warm. They worked diligently at feeding, diapering, and offering a variety of play options. However, these activities of the caregivers seemed, paradoxically, to obstruct interaction among adults and children rather than to encourage it. While Cara was the most withdrawn toddler in the group, none of the ten children seemed able to secure specific engagement with their caregivers in response to their interesting discoveries or through their verbal expressions. They showed little curiosity and spoke or vocalized infrequently. The impression was that as the children failed to be responded to, they came to expect no response, and had begun not to seek any.

Similarly, communication between parents and caregivers seemed almost non-existent. When they did speak to one another, conversation was strained and stilted. The presence of parents in the room seemed to confuse further what the children's relationships with their caregivers should or might be. No one appeared to understand who was responsible for the children; no one addressed the confusion parents, caregivers and children were clearly experiencing. Parents' arrivals and departures were particularly awkward and silent.

The consultant began meeting with the director and the toddler room staff. Although the consultant's initial questions pertained to Cara, staff began over time to think about their experiences with other children and families in their program. They realized that because of her temperament and previous experience in other relationships, Cara was expressing distress in more discernable ways than the other toddlers. But as discussions with the consultant continued, the caregivers began to recognize the impact of a general lack of relatedness throughout the program on other toddlers, on parents, and on themselves. It was particularly important for caregivers to reexamine their perception that they existed for the children only at those moments when they, the caregivers, chose to relate to them. When they came to see that they were an important part of the children's experience *all* of the time in day care, they could begin to appreciate that the children might often feel alone and abandoned.

Now discussion could begin about what the caregivers' relationships with children could be. Their new sense of significance did not mean that caregivers had to, or were able to, become single-mindedly invested in interacting with an infant every minute. Rather, once they were aware of themselves in a relationship, they

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could focus on the infants rather than on the particular activities of feeding, diapering or presenting objects.

The caregivers also came to think differently about their importance to parents as they recognized the need for all the adults in a child's life to share an understanding of the child's ongoing experience. Rather than simply presenting parents with charts of bowel movements and feeding times, the caregivers began sharing anecdotes that provided parents with a way of participating in their child's experience even though they were separated from one another. As parents were able to reciprocate, the caregiving adults—parents and child care staff—knew both the child and each other better. Rather than feeling either competitive with one another or totally and separately responsible, they could begin to recognize their shared responsibility for the child.

Changes and choices: Program consultation

The following glimpses of the initial sessions of a program consultation illustrate the many levels of intervention and numerous relationships involved in this type of consultation.

The new program director of a very large, subsidized day care center called for consultation. He was concerned about the level of distress, apathy and resignation that seemed pervasive among the staff in one of the center's classrooms. But new on the job and pressed by multiple demands, he could not offer ideas about why the classroom staff and children were suffering.

An observation and a discussion with Paula, the head teacher, suggested to the consultant that the preponderance of particularly difficult children in this classroom contributed to some degree to everyone's sense of helplessness. But so did recent changes and cutbacks in personnel. Change itself—the way it occurred and its effect on both caregivers and children—became the focus of several meetings.

In her first meeting with the consultant, Paula expressed a wish to make more changes in her own staff and curriculum. She felt no hope, however, that the classroom aides would support any of her ideas. In exploring with Paula why the aides might lack the enthusiasm and interest which would be needed to make successful changes in the classroom, the consultant realized that the notion of change that was inspired by interest and enthusiasm was foreign not only to her aides but to Paula herself.

Meetings with the classroom staff, all of whom had worked in the center for more than ten years, revealed that change in the center had come to be associated inextricably with loss—loss of staff, loss of pay, loss of vacation time, and, most significantly, loss of control. Change, in their experience, simply meant being acted upon. The consultant reflected on the impact of these experiences. She also recognized that even meeting with her, given the fact that they had not requested the

consultation themselves, might seem to the staff like another unwanted change, a burden added to an already overwhelming job.

The opportunity to choose change, rather than succumb to it, ultimately allowed this staff to remember what it was they had once enjoyed about their jobs. They were able to envision ways in which they could improve their program. Not surprisingly, the process of implementing change was more significant than the programmatic change itself. For example, when staff members were able to anticipate and control the changes in routine involved in introducing a morning free play period to the program, they became able to think about the importance of preparing children in advance for the new format. Passing along the control that they had been allowed to take, staff could give children choices about where and with whom they wished to play.

But the new free play period meant that children now needed new kinds of assistance from the staff, who once again questioned their abilities and their relationships with children and each other. An aide, apparently uncomfortable in the unstructured play period, reverted to ritualized preparation of snacks or monitoring of the bathroom, tasks she had previously been relegated to perform. The head teacher was able to convey her irritation to the consultant, but not directly to the aide. The consultant now worked to understand the meaning of the aide's behavior; to acknowledge the head teacher's distress while helping her gain empathy for her staff member; and to help the head teacher understand some of the ways in which her own past experiences made it difficult to express concerns to staff. Within the network of trusting relationships that had been established, difficult feelings could be expressed and new ways of relating to children supported.

Promoting and safeguarding early relationships in child care: The Child Care Dallas Family Day Home system

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Our programmatic response to infant mental health issues in day care should be seen in the context of policy as well as practice. For some babies and their mothers, "good enough" day care supports development; for others it will not. What if day care itself is the or a pathogenic factor in an infant's development? Are we attempting to cure a disease we have created? How do we differentiate among babies' needs? How do we "protect" the ones for whom "good enough" day care does not suffice?

The fact that we develop the best possible program design for infants in day care, or shore up relationships and development with consultation, should not take our energy and attention from the needs of all babies to have a primary, intimate, ongoing relationship with an emotionally invested caregiver for whom this baby has special meaning and importance.

Parental leave provides an opportunity for the primary parent and baby to attach before other caregivers enter the relationship. It is this kind of policy, combined with sound child care programs and practices, that we need to foster the healthy development of infants and families.

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Child Care Dallas is an eighty-nine year old United Way and federally funded day care agency that cares for some one thousand infants, toddlers, and preschoolers daily in a variety of settings and programs. An infant mental health perspective is a central influence upon Child Care Dallas program design, especially in those settings which the Agency manages directly. We are determined to safeguard to the greatest extent possible the infant's development of a sense of self within meaningful, positive relationships. To this end, we have looked for ways to assure: 1) continuity of caregiving, both during the child care day and over time; 2) protection of the primacy of the parental relationship through parental control over and access to the child care setting; a sense of intimacy in the child care experience; and placement of siblings together. A family day home system has seemed to be the best way to assure that the same person relates to the infant and family each day, that the young child is cared for in a small group, and that the entire experience retains an intimate, domestic quality for everyone involved.

Program and social work staff at Child Care Dallas have developed several strategies to make this vision work as an ongoing system to assure that child care settings foster the healthy development of infants and families.

The ongoing relationship between the agency and the family day home mother begins with a social study of each family day home. The strengths and weaknesses of the home are evaluated with a view to understanding what kinds of infants at what developmental stages this

particular home could nurture well. The worker explores the day care mother's motivation for this kind of work, her feelings about young children, her own in-home relationships, her thoughts about dealing with isolation and loneliness, and her attitudes about childrearing. She is invited to describe her own experiences of loss and separation, and to think about the kinds of behaviors in infants and toddlers that she finds appealing or unappealing. The prospective family day home mother is encouraged to express and reflect on her feelings about working parents who place their infants in child care and, given that Child Care Dallas serves Protective Services clients, about parents who might neglect or abuse their young children. It is our experience that providers' feelings of competitiveness or differences in values between provider and parent, can be addressed and resolved—but only if opportunities are offered for them to be recognized and expressed. The social worker is especially sensitive to the caregiver's ability to understand that her own history has something to do with the quality of the care she will be able to give infants and families.

The placement process with the family is similarly attentive to emotional issues. A child and family history is taken which includes experiences of pregnancy and childbirth; current developmental information; previous separations of parents and child; previous child care experience; and information about how the infant communicates distress and can be comforted. Parents are asked to describe what they particularly value in their child. They are invited to discuss their expectations about their relationship with the day home mother. With some 50 homes in the Child Care Dallas system, families do have choices about placement. They are encouraged to visit several homes to see which seems most consonant with their own needs and feelings.

The agency works with parents to take a careful look at the beginning of the child care arrangement, with visits planned to the family day home before care begins. Discussion is encouraged about the distress both infant and parents feel as separation occurs. When, as sometimes happens, infants and toddlers do not show developmentally appropriate distress in the unfamiliar setting, we are concerned. We work with the family day home mother to gain a better understanding of the quality of the infant's relationships and to think about ways of strengthening the child's important relationships, both with the parents and with the family day home mother.

A detailed annual program audit provides a way to look at the experiences of infants, parents and caregivers over time. We meet with each family day home mother to review the physical environment, safety, health practices, play opportunities, awareness of children's development, opportunities for communication of feelings, how parents are involved in encouraging the child's development, and relationships with parents. We then use the results of that review as a guide for the ongoing work with the child development specialist, social worker, and day home mother.

Assessment of infants and toddlers in care several times a year allows the agency to know where children are developmentally, and to plan genuinely individualized programs for each child. Our assessments have been based on observations of the child across various developmental domains. We are exploring the use of Gilbert Foley's Attachment/Separation/Individuation Index to focus our assessments on the child's achievement of self and object constancy, those developmental achievements most at risk in substitute care. When our assessment observations have been made and summarized, we meet with parents to share our impressions and to get their perspective on the child's development.

If worries about an infant or toddler's development are expressed by the parent, the day home mother, the child development specialist who visits the day homes monthly, or the social worker who is in contact with the parents, a staffing is scheduled to share information and think through strategies. Just as we value the overall primacy of the parental relationship, so we try to protect the primacy of the day home provider/parent relationship. Rather than adding another professional to the equation, we try to help the day home mother work directly with the parents to share and resolve concerns about a child's development. Of course, when specialized help outside our system is needed, we will work to arrange this.

Our system is an evolving one. We have seen important positive changes and are continually looking for new ways to understand and protect the emotional well-being of infants and toddlers in child care.

Reducing turnover among family day home mothers as well as professional staff has been a prime goal, a prerequisite for creating a child care system where continuing relationships can be relied upon. As we work with day home providers, we have encouraged more autonomous functioning among them, supported professional accreditation, and offered increased pay to providers who increase their professional skills, provide consultation to other day home mothers, or conduct training workshops. The turnover rate among family day home mothers has decreased from 40 percent annually three years ago to less than 20 percent this year. Similarly, by making professional staff in the central agency accountable for their own specialized work—child development or social work—rather than generally responsible for management of the family day home system, we have increased satisfaction and reduced turnover among these employees as well.

We continue to be concerned about the central aspects of emotional development that may be at risk when infants and toddlers are in child care. Including the Attachment/Separation/ Individuation Index as part of our periodic assessment of children will give us a more sophisticated understanding of how they are faring in these areas. While our outcome research to date has looked at how well children who have been in our day care programs function in school, we look forward to developing outcome measures that will reflect children's level of success at the central tasks of the first three years of life—at the quality and nature of their human relationships.

An infant mental health training model for day care professionals: The C.M. Hincks Institute National Day Care Training Project

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Recent infant observational and attachment research emphasizes the importance of the earliest infant-caregiver relationships for the development of optimal human functioning. The quality of a child's various attachment relationships seems to have more to do with that child's development than whether or not the young child was cared for solely by parents or in a day care setting as well (Morris, 1989, personal communication). Therefore, anyone involved with the early caretaking of children needs to understand the importance of a hierarchy of attachment relationships to the child's emotional development, as well as the effects of an equivalent hierarchy of separation experiences. It is also important to understand the mutual impact of relationships that cross generations and involve many parts of the young child's world—the family, day care providers, day care institutions, and societal and political systems (Bretherton, 1985; Emde, 1988; Fraiberg, 1980; Main and Goldwyn, 1984; Stern, 1985).

To achieve such understanding, however, involves—for most of us—learning to see, know and feel what we have previously avoided seeing, knowing and feeling about infants' experiences in relationships (Bowlby, 1979; Tuters, 1988; Tuters et al., 1989). Our avoidance may stem from defenses of thought established in the course of our own efforts, as infants, to cope with failures in attachment relationships. Reflected in the society at large, such avoidance may take the shape of training for early childhood professionals that specifically excludes attention to emotional development, or of social policies that dismiss the relationship needs of infants and young children.

Precisely because day care facilities in Canada are relatively closed to the influence of children's mental health professionals, we at the C.M. Hincks Institute for Training, Research and Resource in Toronto decided to train day care staff themselves as mental health consultants and involved the day care system in planning the training program.

In a federally funded pilot project, the Clinical Infant Program of the C.M. Hincks Institute is training three day care fellows per year, selected from senior day care providers who are interested in expanding their role and the quality of day care in the community. Fellows gain expertise in mental health consultation to day care while sharing a common core curriculum with other mental health professionals in training at the Institute.

As we planned the training model, we knew that the day care fellows would come to us well-trained in behavioral, physical, cognitive and social development. We wanted our curriculum to include knowledge of psychoanalytic concepts, with an emphasis on individual development over time; knowledge of attachment issues; knowledge of family relational systems; and knowledge of consultation and system sensitivity. We knew that our greatest challenge would be designing training that would be acceptable to, and congruent with, the requirements of day care while, at the same time, helping the day care fellows come to see, know and feel what they had previously been avoiding seeing, knowing and feeling.

The fulcrum of the learning experience of our day care fellows is observation—of infants, of small children, and of assessment and treatment. Structured observation, an accepted part of the training programs for child psychotherapists in many countries, including Canada, is an emotional learning experience. Trainees experience the impact on themselves of observing the developing infant, through understanding the feelings aroused in themselves. For day care provider trainees this means becoming able to see what in the past they have been unable to recognize: that is, the pain and distress of an infant or small child and his parents separated from each other; the effect of this experience on the developing child, on the parents, and on the day care providers; and how they all cope.

Infant Observation involves the student in weekly in-home observations of the developing infant in the family, from birth over a period of one to two years. Observations last from 45 minutes to an hour, with the observer behaving as naturally as possible but interacting minimally with the infant and family. Note-taking is discouraged; narrative descriptions of the observation are written from memory and discussed in weekly seminar groups. The observations that have been described, and feelings that have been stirred up, are shared with other group members and worked through in discussions. The Small Child and Clinical observation seminars follow a similar format.

Our training program for three fellows (a masters level teacher of early childhood education at a community college; a masters level day care supervisor; and a doctoral level consultant to infant day care programs) has been underway since September,1989. Vignettes from the observation seminars exemplify the trainees' learning experiences, and so far serve to validate our expectation of the powerful impact on the self of learning through observation.

A vignette from the Infant Observation Seminar

As she described interactions between the mother and the older toddler sibling of the target infant, the trainee herself expressed concern that although she was meant to be observing the infant in the family, she was bringing to the seminar observations only of theinteractions between the mother and the toddler. She said, however, that it was not possible to observe a feeding or sleeping baby. Seminar members acknowledged the difficulties of observing without impinging on the mother's or infant's space, but described their own observations of feeding or sleeping infants. A question was raised concerning how much the mother being observed was able to become preoccupied with her infant while she felt so compelled to attend to her older child's needs. It was as if, at those times, the infant did not exist.

The observer became painfully aware that she, like the mother, but for her own personal reasons, had not been able to "see" the infant. The seminar group had

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helped her discover something about herself and her experience of infants which she had hitherto avoided knowing.

In this same seminar session, another trainee became aware that she too was avoiding self-knowledge. In her own observation, she visited a mother who, depressed and discontent with her third baby, indicated in conversation that she felt she could not meet the needs of her infant because her own needs were not being met. The observer described finding herself not observing the baby, but rather engaging in conversation with the mother about knitting. She realized that she had been pulled into this mother's world, colluding with the avoidance of her infant's needs.

A vignette from the consultation application seminar

The day care fellow reported that the day care teacher of the small child being observed by the trainee asked her how long and for what purpose the trainee would be observing the child, indicating that she felt it was a waste of time. The teacher also inquired about the in-home observations this trainee had made of this child. The trainee carefully explained the purpose and duration of the observation and clarified boundaries with respect to confidentiality. The following week, the same teacher repeated the same questions. She added that she too was planning to further herself; she did not intend to remain a day care teacher forever.

The trainee could recognize issues of confidentiality and competition and had begun to understand the existence of many levels of communication and the power of personal issues to influence behavior. As she thought about the impact of the teacher's communication on her, she was left feeling lazy and advantaged, in comparison with the relatively deprived, hardworking day care provider. Her clarification about limits on the sharing of observational information increased her sense of being perceived as a person who "had it all" but was withholding what she had (desired information) from the needy teacher.

Whenever the trainee offered some thoughts about the children's behavior, this day care teacher was quick to minimize her contributions. When asked by the trainee for her own thoughts about any behavior or interaction, the teacher would make a brief, dismissing comment, indicating to the trainee the teacher's reluctance or resistance to attempting any understanding beyond a superficial level of the meaning of a child's behavior. The day care fellow was left feeling that she could not communicate clearly—that her own behavior (as someone who believed that observation and understanding a small child's emotional experience were important) could not be understood by this teacher. This would seem to parallel the child's situation.

We believe that training based on observation helps trainees fully understand the impact on themselves of the experience of day care and all of its vicissitudes. Our training helps them understand the experiences of infants, children, families and day care providers. They come to understand how much the source of a child's distress lies within the family system, how much in the day care system, how the interrelationship of day care and family systems impinge upon a child's emotional experience, and how intergenerational repetitions can become intersystemic re-enactments. To struggle with what needs to be done in the earliest years of life is to make possible different outcomes for infants and small children, for families, and for day care providers.

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Models of Integration Through Early Intervention/Child Care Collaborations

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Families of young children with disabilities, like all families, have many roles and functions to fulfill. One of the most important functions is the need to work for a living. Infants and toddlers with disabilities, like people of any age with disabilities, deserve opportunities to participate in the typical experiences of their culture. Delivering early intervention services within community child care programs offers an opportunity to support the development of young children with disabilities and their families through the kinds of comprehensive, community-based, family-centered services envisioned by P.L. 99-457. Yet the challenges of such a model to both the early intervention system and the child care system are many.

Connecticut, Delaware and Massachusetts are three states that have accepted this challenge. Each state is currently developing model early intervention programs within community child care settings. Each is using a combination of federal and state funds to provide a variety of services to enrolled children, families, and child care staff. This article, based on a symposium presented at the National Center for Clinical Infant Program's December, 1989 National Training Institute, will describe activities within each of the three states and discuss issues of service delivery, training, policy development and evaluation which have emerged in all of the states' efforts.

Connecticut

The state of Connecticut has been allocating funds to train day care providers to serve young children with special needs for the past three years. The Department of Human Resources and the Department of Mental Retardation have been contracting to the Division of Child and Family Studies, Department of Pediatrics at the University of Connecticut for this training. The Division has also received a federal in-service training project (HCEEP), The Day Care Training Project, to develop a model curriculum on the integration of children with special needs into day care centers. Additionally, the Division has two demonstration projects (HCEEP), jointly referred to as the Early Childhood Special Education Community Integration Program, funded to assist existing early intervention agencies (Department of Mental Retardation for children birth to three; Department of Education for children three to five) to expand their service delivery options into community day care settings and nursery schools.

Delaware

The state of Delaware has also been using both state and federal funds to train day care providers. Delaware First was a three year statewide demonstration project (HCEEP) designed to provide quality early intervention for handicapped and at-risk infants and toddlers in mainstreamed family day care homes. Project designers recognized the potential of family day care, where six children or fewer are cared for in the provider's own home, to offer the individualized care needed by children with disabilities. A second goal of the project was to facilitate both formal and informal support systems for families by providing respite and a break from caregiving responsibilities for some families, while providing high quality child care for employed parents of young children with disabilities. The third goal was to increase the number of family day care providers throughout the state trained to care for special needs infants and toddlers. A second effort, Project Del Care, has used state P.L. 99-457 funds to expand this model to center-based child care programs.

Massachusetts

The state of Massachusetts is using P.L. 99-457 Part H funds from the Department of Public Health to support the Day Care/Early Intervention (EI) Collaboration Pilot, to develop day care/early intervention collaboration projects at four sites. Activities at each site include selection of children to be enrolled, joint child and family assessment, the joint development of Individual Family Service Plans (parents, day care and EI staff), establishment of a working partnership, defining the role of consultation for each program, working out role definitions to highlight the strengths of each service type and working closely with the 8 to 10 families participating at each of the four sites. Each of the four partner sites proposes to target children for these combined services who are at high risk for developmental delays due to environmental risk factors.

Although the model projects differ somewhat among the states, a number of issues recur as early intervention services are integrated within child care settings. These issues cluster around service delivery, training, evaluation, and policy development.

Service delivery

The identification of children who are eligible for early intervention services represents a service delivery issue in all three states. The project currently underway which deliver early intervention within the child care setting are focused on young children who are already identified as eligible for these services. In addition, however, the Del Care Project (Delaware) and the Day Care Training Project (Connecticut) train child care providers to identify children in their programs who may be eligible for additional services.

The issue of who pays for early intervention services delivered within the community child care setting has

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been a central one in each state. Complicating this issue is the existence of very different traditions in paying for early intervention and for child care. Early intervention services for infants and toddlers with disabilities—where they have existed under state auspices and with Medicaid reimbursement—have typically been provided at little or no cost to families, regardless of family income. Child care, however, has generally been regarded in this country as the financial responsibility of the parents, although tax credits and some direct subsidies have eased the burden for some categories of families.

In Massachusetts, a fifteen month Dept. of Public Health grant to each of the four participating day care/ early intervention programs covers: 1) the costs of day care for 8-10 children per site; 2) the costs of transportation to the day care site; 3) costs of liaison activities by a designated member of transdisciplinary team of each collaborating early intervention program; and 4) salary of a developmental educator or social worker for the day care program. The cost of specialized Early Intervention services is provided through the combination of state, federal and third party funding sources used by all 43 DPH Early Intervention Programs.

The Connecticut funding pattern reflects the conflict between early intervention and child care financing. If an early intervention team determines that an infant or toddler should receive early intervention services within a community early childhood setting, the Department of Mental Retardation will generally pay for part-time participation in the child care program (for children birth to three). If parents wish to use the site for full-time child care, they must pay the additional costs. (The local Education Agency follows these same procedures for children age 3 through 5.) In addition to child care fees, the early intervention agency pays for whatever specialized services are outlined in the IFSP. These typically include direct services to the child or consultation to child care staff by a special education teacher and other professionals. In some cases, the costs of instructional aides and adaptive equipment have been covered. Transportation can be provided by an early intervention program bus or reimbursement to the family.

The Delaware system is still evolving. The Del First project paid the full child care costs for 21 infants and toddlers with special needs who were placed in family day care homes. The Del Care project, a center-based initiative, offered to pay centers' standard child care rates for children with special needs but found child care centers unwilling to participate on this basis. Recognizing the additional costs to child care programs for the extra planning and record keeping involved in participating in a demonstration project, Del Care now uses a sliding scale, with rates based on the additional effort required to serve specific children. All programs are given at least $50 a month for planning, record keeping, working with the project staff and implementing the child's IFSP. A provider caring for a child with an overall developmental delay receives an additional $100 a month; a program serving an extremely involved child who requires tube feeding and extensive stimulation might receive an additional $150.

The overall quality of caregiving within participating day care programs is another service issue within all states. When program quality is poor, the development of any young child, regardless of special needs, is affected adversely. Both Delaware and Connecticut use Thelma Harms' Family Day Care Rating Scale or Early Childhood Environmental Rating Scale, to screen all potential child care sites. The Connecticut Early Childhood Special Education Community Integration Program uses an internally developed site selection tool.

Unfortunately, the high demand for quality infant and toddlers child care far exceeds the supply across the country. Providers have a wide range of formalized training, observational skills, and ability to nurture and care for very young children. In center-based care, particularly, one needs to be alert to whether the quality and amount of individual attention provided is enough to meet the special needs of infants and toddlers with developmental delays or disabilities. Quality of care may vary greatly within a child care setting. Del Care project staff report the greatest diversity among one-year-old and toddler classrooms. Massachusetts currently provides a large system of subsidized day care for working parents and parents participating in educational and training programs. One infant care model being used is the "primary care" model where one caregiver is assigned to 3 or 4 infants or toddlers to promote consistency of care and bonding between caregiver and child.

When staff in the Connecticut and Delaware projects have felt that they are working, for lack of alternatives, with child care providers who are not offering high quality care, they look for opportunities to offer consultation and support. Good rapport (perhaps facilitated by monetary incentives) between early intervention and child care staff is essential. The fact that in the Del Care Project, project staff select the classroom for each child with special needs provides

an opportunity to discuss with the child care program director the variability of quality between classrooms and ways to bring about improvements.

In all three states, staff turnover within both early intervention and day care programs is high, affecting the quality of children's experience. Family day care homes have the most stable staff; however, the numbers of these placements (in Connecticut there are over 5,000) and the limited number of children within each (6) create a very large system to work with. It should be noted that the national turnover for day care providers is at 41% due to a number of reasons, primarily pay ($5.35 an hour nationally).

Training

Training is a primary service of early intervention/child care collaborative projects in all three states. Massachusetts provided funds for four staff of the statewide child care resource and referral network to receive intensive training regarding infants and toddlers with special needs. These trainers are now teaching a course entitled "Infants and Toddlers at Risk" at four sites across the state. Several of the trainers have chosen to co-teach the course with an early intervention educator and to include presentations by early intervention parents. The Massachusetts Office for Children sponsors this course and an "Infant/Toddler Development" course for college credit, offers workshops through the 12 child care resource and referral agencies and this spring is sponsoring a conference to bring together day care and early intervention staff statewide. The Department of Public Health funds four outreach and training programs that provide training around child health and development issues. The Early Intervention Programs themselves provide child specific services and training to child care providers around children enrolled in child care settings. Early Intervention Staff are provided statewide training through the efforts of the Continuing Education Consortium for Early Intervention Programs and the Massachusetts Early Intervention Consortium (of parents and providers).

Both Connecticut and Delaware offer specific training courses to day care providers. Based on the principles of adult learning, these courses incorporate the concerns and needs of individual providers into the training. The activities of the Connecticut Day Care Training Project range from on-site workshops, to small group institutes of 5-7 sessions, to individual technical assistance. Not only is training free to child care providers, but additional incentives include meals for participants, money for substitutes and/or reimbursement for time spent in on-site training sessions, and continuing education credits.

Early intervention staff have also been the recipients of training through the Early Childhood Special Education Community Integration Program in Connecticut. The content of this training has revolved around early intervention service delivery with a focus on meeting each child's unique needs through team development and coordination with the child care program. The particular focus for the early intervention staff involved in this project has been on their accommodation to their changing roles as consultants to child care programs, and the development of new skills to fulfill this role. These skills have included communication, collaboration, and consultation skills, as well as the management and facilitation of service delivery teams. As with day care staff, the training of early interventionists has incorporated the use of on-going needs assessments and the development of flexible, effective training activities which use adult learning principles.

All three states provide training to families of young children with disabilities. Families have been by far the most responsive and enthusiastic audience. Of some surprise was the extensiveness of family training needs. Most have requested training on basic intervention issues, including their rights and responsibilities under P.L. 99-457 and P.L. 94-142, types and goals of intervention services, funding and reimbursement issues and developmentally appropriate goals and activities.

A major training issue which has emerged from all three projects is the need for more on-site day care consultation, both on general and child-specific issues. In Massachusetts and Connecticut providers of state-subsidized day care systems are requesting on-going, on-site training concerning the many children they serve who are experiencing developmental delays due to environmental factors.

Evaluation

All three states have evaluation plans to monitor their individual projects. Massachusetts is using a process evaluation for the 15-month pilot projects. The main goals of the evaluation are to document: 1) the development and process of program partners working in collaboration; 2) the integration of children into "normalized" settings; and 3) the impact of early intervention services in child care settings on children and families. The evaluation will include a parent questionnaire and a staff questionnaire. The providers will examine variables of family functioning, styles of parent-child interaction and social/emotional and behavioral adaptations of children, as well as assessing and marking children's developmental progress.

Delaware has focused on child change as one indicator of effectiveness. There are problems in this strategy, however. These have included the briefness of the intervention for some children, the difficulty in locating appropriate assessments for children with multiple disabilities, the time lag between initial assessment and placement within a day care, and a general sensitivity to the problems of over-testing children. Delaware is also measuring the satisfaction with child care among parents of both disabled children and non-disabled children, and the environmental changes which occur within participating day care settings.

The training of day care providers in Delaware and Connecticut has been evaluated extensively. An issue which has surfaced has been the use of self-rating scales by the trainees. In both states, trainees rated themselves as knowing less after training than before. In both instances, it was documented that the training made providers newly aware of what they didn't know. Both projects are now redesigning their scales to insure a rating on the specific content of training.

In addition to the day care training outcomes, Connecticut has an evaluation plan which includes child impact (developmental change and behavioral change across a range of instruments), family impact (attitude, use of community resources and support systems, and satisfaction with training and project outcomes), and program impact (early intervention program profiles, early childhood environments and training outcomes). Evaluation outcomes are available on request from all three projects.

Policy development

This area will have the greatest long-term impact on the overall efficacy and usefulness of the early intervention/child care model. According to the Carolina Institute on Policy Development, policy refers to the rules and standards that are established in order to allocate public resources to meet a particular social need. Each of the early intervention/child care initiatives is working with state agencies and advisory boards to establish, refine and evaluate policies which facilitate this service delivery model.

In Connecticut, policies have been initiated within two state agencies responsible for direct early intervention services. The Department of Mental Retardation has revised its early intervention program philosophy to include a statement that "transdisciplinary quality early intervention services for infants, toddlers, and their families will be tailored to each family's needs and delivered in the home or in places that teach or care for typical young children." The Department of Education has focused on the delivery of preschool special education services within a range of least restrictive settings, including nursery schools and day care programs. Local programs have followed suit with changes of philosophy, expansion of program sites in the community and the development of new practices. The advisory board to the Early Childhood Special Education Community Integration Program has been instrumental in developing local policies which include interagency agreements, bus training protocols, practices for "aides" on leave, and time for "teaming" and consultation with community early childhood programs.

An additional policy being investigated within Delaware concerns equalization of caseloads among early intervention staff. For example, a developmentally delayed child from a well-functioning family in a high quality family day care home is one child in the case load. Another child, also diagnosed as developmentally delayed, may come from a home with a single mother who is herself mentally retarded. The child also may have two older siblings in special education, no telephone, and be enrolled in a child care center of questionable quality. Serving these children well does not require equal amounts of time and energy. Child, family and setting variables are being taken into account in an attempt to address and equalize case loads.

In Massachusetts, funding of the collaboration pilot is an expression of a policy goal to expand access and support to child care for children with specialized needs. The approach to interagency policy development involves the encouragement of coordination of services at the local level, while simultaneously sewing a common thread of collaboration and integration through the many early childhood state policy, advocacy and advisory groups. Complementary state efforts include the current revision of the Special Needs Section of the Office for Children licensing standards, the revision of state teacher certification, the use of JEPTA and state Employment and Training dollars to train child care staff, efforts of the Child Care Resource and Referral agencies to assist parents and to recruit providers to serve children with special needs, and the development of a coordinated system of child find and developmental screening.

Conclusion

The states of Connecticut, Delaware and Massachusetts are attempting to expand early intervention service delivery options for infants, toddlers, and their families.

The integration of child care and early intervention services is appealing for a number of reasons. First, families with children with special needs want to be part of community-based support systems designed for *all* children and families. Second, the child who is receiving early intervention services will have the opportunity to learn, practice and generalize skills in a normative environment designed to support all aspects of his development. Third, early interventionists and child care providers will have an opportunity to learn from each other and collaborate on practices that will benefit all of the children enrolled in their programs.

Before model programs become replicated widely, many issues of service delivery, training, evaluation and policy development remain to be resolved. In Connecticut, Delaware and Massachusetts, parents, child care providers, early interventionists, trainers, administrators and policymakers are working together to realize the potential of integrated child care and early intervention services for children and families.

Outreach to Family Day Care: A National Volunteer Initiative

by
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and
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In an attempt to reach out with meaningful support to family day care providers, the National Council of Jewish Women (NCJW) and the Yale Bush Center in Child Development and Social Policy collaborated on the development and implementation of a national volunteer initiative. The initiative, known as the National Family Day Care Project, has been in operation since 1988 in twenty-five communities across the United States. In this article, we discuss the various ways NCJW volunteers address issues related to family day care and the implications of the program not only for the family day care field, but also for other attempts to address social needs through volunteer actions. At the outset, however, it is important that we briefly describe some of the developments that currently characterize family day care, as well as the rationale underlying the conceptualization of a volunteer initiative to address the needs of providers in the field.

Family day care: An emerging field

Parents often choose family day care because they want their children to have the experience of being cared for in an informal, home-like atmosphere. The accessibility and flexibility of family day care, its relatively lower cost when compared to other forms of child care (Department of Labor, 1988), and the lack of center-based facilities may also influence parents' choices. Developmental experts point to the advantages of family day care, particularly for infants. Small group size, the likelihood of continuity of care, and opportunities for individual attention to each of the children are important aspects of good quality child care that may be found in family day care homes.

Although family day care has been for some time the most prevalent form of out-of-home care for infants and toddlers, it has only recently become recognized by policymakers as an important child care alternative and a necessary component of any comprehensive child care policy. This is evident not only in proposed solutions to the nation's child care crisis (Zigler, 1987; Zigler and Finn-Stevenson, 1989; Kahn and Kamerman, 1987), but also in the increase in the number of legislators who acknowledge parental preference for family day care and are considering ways to enhance growth of the field. Kahn and Kamerman (1987) observe that this interest among policymakers stems in part from the belief that family day care is "[an] economical and elastic child care supply" that, with assistance, can be expanded to help meet the increasing demand for child care services, especially for infants and toddlers. They cite a number of state initiatives which illustrate the growing popularity of family day care in the policy arena. In California, a recently developed vendor-voucher payment program enabled state funds to be used in support of family day care rather than continue a trend of nearly exclusive support of center-based care for infants. In several other leadership states, there are efforts to provide incentives for individuals to enter and remain in the family day care field as well as provide training for them. A number of states are also supporting the development and operation of child care resource and referral agencies and family day care associations which recruit and train providers.

SUBJECTS & PREDICATES

These state initiatives are encouraging, but they represent minimal policy attention to family day care and only a token of what can be done nationally to stimulate growth in the field and improve working conditions for providers. In some European countries, public policies are based on the rationale that infants and toddlers whose parents are working are best taken care of in a home setting (Moss, 1988). These policies include provisions to guarantee a basic salary for home providers as well as ensure that such providers are recognized as part of the formal economy (Deller, 1988). In the United States, we still lack a comprehensive child care policy. Yet, even the legislative proposals now being considered in Congress tend to favor center-based child care, despite the fact that family day care is "where the numbers are" (Kahn and Kamerman, 1987).

Differences among providers

The varied nature of family day care may be its most salient characteristic. While to some extent it is variety that makes possible good matches between child care providers and the individual needs and preferences of families, at another level variability poses an enormous challenge to research, assessment of the quality of care, and training.

Variability is especially apparent when efforts are made to characterize family day care providers. In an attempt to better understand providers in order to improve local recruitment efforts, for example, Perreault (1985) identified thirteen different categories of motivation that drew people into the field of family day care. Some providers have grown—or young—children and need additional family income; others are AFDC recipients who want to supplement or become independent of welfare benefits. Some regard family day care as a profession; others, as a stepping stone toward the goal of owning a day care center. Some providers enjoy caring for particular kinds of children and may, for example, specialize in infant care. Others see themselves as babysitters and enter and drop out of the field with little planning, depending on their immediate financial needs.

Kahn and Kamerman (1987) identify a growing segment of family day care providers who assume leadership roles in their respective communitites and regard themselves as change agents. These providers are more likely than others to attend conferences and workshops, acquire publications and materials pertaining to family day care, and belong to family day care associations, resource and referral agencies, or family day care systems, which are networks of homes operating under the umbrella of a sponsoring organization.

Famiy day care providers differ not only in their motivation, but also in their educational background, experience and caregiving skills. They live in every type of neighborhood (encouraged or encumbered by widely varying zoning regulations). They are largely unregulated by local or state governments, again for a variety of reasons, including short-term involvement in the profession, lack of awareness of the benefits of regulation, and a perception of licensing and registration as costly, unnecessary government intrusion (Kappner, 1984).

The National Family Day Care Project

The largely unregulated nature of family day care (Lawrence and Brown, 1989) and the variability which characterizes the field mean that the estimated 1.5 million family day care providers in this country are likely to be isolated from others in the community, lonely (Modigliani, 1989), and difficult to reach with training that is appropriately individualized in type, level and intensity (Corsini et al., 1988; Eheart and Leavitt, 1986). Moreover, the communities in which providers live vary greatly in the resources available to address providers' needs, as well as in their attitudes and policies (at both the local and state level) toward child care in general and family day care in particular.

The Yale Bush Center considered these issues in conceiving a national strategy for supporting family day care providers. The converging interests of the Yale Bush Center and the National Council of Jewish Women resulted in the National Family Day Care Project. The project was designed as a three-year effort, with the idea that the initiative will become institutionalized at the local level and that dissemination will begin nationally after three years.

The National Council of Jewish Women is assuming a leadership role in implementing the project. NCJW is collaborating with child care resource and referral agencies, family day care provider associations, government licensing agencies, mayors' offices, state Associations for the Education of Young Children, the Junior League, the League of Women Voters, the National Black Child Development Institute, Alpha Kappa Alpha Sororities, and the Kiwanis Club. At the national level, NCJW is collaborating with colleges and universities, selected foundations, and other national organizations working in the area of child care and work and family life.

NCJW brings three major strengths to the effort: the 100,000 NCJW volunteers have a strong local presence in 200 communities (referred to as NCJW Sections) across the United States; NCJW volunteers have had extensive experience in child care issues and a history of working on matters pertaining to child care and work and family life; and a strong link exists between NCJW's staff at the national headquarters and the volunteers at the community level. Given the fact that the project seeks to address the needs of a rather complex field and the assumption that at least during the initial phase of the project the volunteers would need guidance and support, this national/local link is particularly important.

At the time the project was being discussed only two of NCJW's 200 Sections were involved in family day care activities. Once the planning was underway and the NCJW national board made a commitment to highlight family day care, volunteer interest became so great that 25 Sections elected to participate in the three-year initiative, which had originally been planned to involve only 15 Sections.

Goal of the Project

The overall goal of the National Family Day Care Project is to increase the number of good quality family day care homes through outreach and support activities. Since communities are characterized by different needs and resources, the volunteers in each community participating in the project have identified their own specific goals and objectives.

The initial task of each participating Section was to conduct a needs assessment; network with key players and organizations in the child care community; create, or in some cases, join an already existing advisory group; choose a specific initiative or activity pertaining to family day care; and identify resources and assistance needed to carry out the activity.

Activities

The types of activities the volunteers chose differ from community to community, reflecting not only the differences that exist among communities, but also differences in interest and resources among volunteers in the different NCJW Sections. In some cases,

volunteers assist providers directly with cash grants, other material resources, and/or training. In other cases, volunteers work to enhance public awareness of family day care issues or advocate with community and legislative leaders.

In some Sections, volunteers focus on provider recruitment and retention, the goal being to increase the supply of good quality, regulated, family day care. Volunteers identify and orient potential providers and help them through the process of becoming regulated; and advocate for improvements in regulatory procedures and standards. They also organize and provide on-going training for providers.

In other Sections, volunteers have elected to develop resources to help providers deliver quality care, run a small business, and avoid burnout. The types of activities conducted in efforts to meet this goal include: creating resource rooms and purchasing mobile vans to make educational materials and training available to providers; organizing training workshops for providers; producing directories of services for family day care providers; organizing community-wide events to recognize family day care providers; and establishing small grants programs to assist low income providers with start-up costs and other expenses associated with efforts to meet regulations. In some Sections, grants of up to $200 were made to fifteen providers, in other Sections, $150 grants were made to twenty providers during the first phase of the effort.

Several Sections elected to focus their efforts on zoning advocacy in order to remove barriers to the existence and expansion of family day care posed by restrictive zoning ordinances and procedures. These Sections engage in advocacy activities at the local level, they also assist individual providers who are seeking zone changes to enable them to operate a family day care home.

One NCJW Section is developing a center-sponsored family day care home network so that providers can become affiliated with the center in the vicinity of a child center and partake of training and other benefits.

Finally, a number of Sections are undertaking public education campaigns in order to assist parents in choosing a family day care home, encourage policymakers to support family day care, and/or raise public awareness of the value of family day care. Volunteers in some Sections are sponsoring legislative conferences on family day care and writing and distributing position papers on issues pertaining to the field. In one Section, volunteers were instrumental in starting a regular child care column in the local newspaper.

Staff assistance

The project was designed to provide assistance to volunteers during the first three years of implementationl The type and degree of assistance varies among Sections. In about half of the cases, Sections requested assistance with their effort to reach out to and begin working with the child care community in their locality. The project's national advisory board and staff helped them develop good working relationships to complement existing community efforts. Once the goal of the project and the nature of the volunteer activities were explained, the volunteers were able to receive support and begin networking with key players in the community.

Several Sections asked for specific resources such as information about family day care that could be used in funding proposals and information about potential liability problems associated with center/family day care alliances. In assisting volunteers, NCJW staff rely on their affiliations with other national organizations and information compiled from contacts with the academic community and practitioners across the nation. As the volunteers become familiar with family day care issues nationally and in their own communities, requests for assistance from NCJW staff are expected to decrease.

Assistance to volunteers is provided at regular intervals through telephone contacts which include structured questions designed to encourage volunteers to identify and discuss problems they encounter. In addition, an annual national conference of representatives from each of the Sections enables NCJW staff to conduct orientation and follow-up workshops to acquaint the volunteers with issues and provide them with an opportunity to learn from one another. A project newsletter is being prepared to enable volunteers working on family day care issues to share information with one another and keep abreast of developments. Other publications will serve as guides to expand community action in the family day care field and assist NCJW and other volunteer groups in replicating National Family Day Care Project initiatives.

Implications

Although it is too early to ascertain the full impact of the project in the twenty-five communities, some success is already evident. Since the inception of the project, local NCJW groups have leveraged funds to support the purchase and provision of resources for providers, print and distribute consumer education materials on matters pertaining to family day care, and provide training and technical assistance to providers. It appears that it *is* possible to mobilize volunteers and, by providing them with technical assistance and support, enable them to address a social need of national proportions.

Family day care affects the lives of millions of infants, young children, and their families. Since providers can only be reached through a strong, grass-roots effort, community-based volunteer initiatives can be particularly helpful in strengthening this system.

There are other social issues that may be addressed through a coordinated volunteer initiative, and many areas where volunteer action has already proven effective. At a time when public resources are severely limited and the private sector is inundated with requests to fund an ever-increasing number of social programs, it is important to identify those specific social needs that can be addressed effectively by the time and

resources of organized volunteers. Those who would plan a significant volunteer initiative should be sure that the issue lends itself to a grass-roots effort; volunteers make a commitment to work on the effort over a sustained period of time; resources are available to provide volunteers with direction, assistance and support during the initial implementation period; and resources are available to replicate successful efforts.

For more information on the National Family Day Care Project, contact the National Council of Jewish Women, Center for the Child, 53 West 23rd Street, New York NY 10010.

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NICHD Infant Child-Care Network: The National Study of Young Children's Lives

by

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More than five million infants and toddlers under the age of three have mothers in the work force. Families must find care arrangements for their children without the benefit of definitive or sufficient scientific evidence about how the new life circumstances are likely to affect their family relationships and the development of their children. The fact that so many families are bold enough to engage in ways of living and rearing children that are so different from patterns of the past, suggests that many are feeling generally good about their decision and about the development of their children. Others, however, worry.[1]

It is not clear to observers of child and family development under what conditions such parental worry is justified. Not all alternate care experiences are identical. Infants enter alternate care at different ages. They vary in the number of hours they are away from their mothers. Care situations vary tremendously in quality, and the children come from home environments that vary in the extent to which they are conducive to optimal development. It makes sense to assume that some combinations of child rearing conditions are worrisome, while others are supportive of optimal growth. Yet, the specific combinations of such conditions and their specific outcomes have not been documented to date.

Parents, scientists, and policy makers need to have more information than is now available about (a) the complex interaction among factors (including alternate care) that influence the development of young children, and about (b) the effects of different alternate care conditions on the lives of children and their families.

Such information can emerge from the accumulation of findings from many small studies, each focusing on some of the questions at issue: Scientific knowledge usually grows in small steps, based on many studies that together lead to the confirmation (or refutation) of a theory or a world view.

[1]For example, consider the front page article titled "Area Parents Torn by Day-Care Angst" published by the Washington Post on Sunday, September 3, 1989. The article, based on a survey of 807 Washington area parents, reports that working parents feel intense conflict over having their children in day care, and many have sacrificed career advancement to spend more time with their children. Thirty-seven percent of the parents felt that the effects of alternate care is negative; 23% said the effects were positive; 20% said there was no effect, and another 20% said they did not know.

In that survey, 48% of the women and 26% of the men reported that they had taken an unchallenging job that allowed them time or flexibility to care for their children.

In the case of questions that are of great complexity and social urgency, however, the scientific process can be speeded up by designing large studies that allow the exploration of complex relationships between multiple variables. This paper focuses on the development of one such study.

The creation of the NICHD child-care research network

In October, 1987, the National Center for Clinical Infant Programs convened 16 leading child care researchers to an "infant day care summit meeting." The leading researchers reviewed what is known in the area of day care research, and made substantive suggestions for new directions. In addition, they recommended the initiation of parallel longitudinal studies, in which investigators in different parts of the country could use some common measures in their research.

Dr. Duane Alexander, Director of the National Institute of Child Health and Human Development (NICHD), was present at the "summit meeting," as a listener, and so was the author of this paper. Soon after that "summit," the National Institute of Child Health and Human Development announced a request for research applications. In this call for applications, the Institute expressed its interest in supporting a collaborative, multi-site, longitudinal, prospective study that provides interrelated, detailed information about the following:

(a) the care that infants of employed mothers receive when their mothers are at the work place; (b) the care these infants receive when their mothers return from work (e.g., during the evening or on weekends); and (c) the emotional, social and cognitive development of children of employed mothers about whose care in infancy information is available.

As a consequence of this request for research applications, and following peer review, NICHD has created a network to study the effects of infant day care on the development of children. The research network includes investigators from ten different research sites across the United States. Twelve hundred infants will be recruited into a five-year study that is expected to be completed in 1995.

The 10 research sites are at the University of Arkansas, University of California—Irvine, University of Kansas, University of Pittsburgh, University of New Hampshire, Temple University, University of Virginia, University of Washington, University of Wisconsin and Western Carolina Center. These different sites provide geographical diversity and, consequently, the potential for a heterogeneous subject pool.

The study is being developed by a steering committee consisting of the principal investigators of the study, NICHD staff, and an independent chairperson. The committee is assisted by a statistical consultant. Data management, monitoring, and analysis will be carried out centrally by NICHD.

Members of the steering committee are Drs. Jay Belsky, Cathryn Booth, Bettye Caldwell, Alison Clarke-Stewart, Martha Cox, Sarah Friedman, Aletha Huston, Kathleen McCartney, Deborah Phillips, Henry Ricciuti, Deborah Vandell, Marsha Weinraub, and Sumner Yaffe. The statistical consultant is Dr. Mark Appelbaum. Also participating in the study are the co-principal investigators and additional NICHD staff. These include Drs. Robert Bradley, Ceila Brownell, Susan Campbell, Jeffrey Cohn, Carl Dunst, Jean Gowen, Ellen Greenberger, Kathryn Hirsch-Pasek, Nancy Marshall, Marion O'Brien, Margaret Owen, Sandra Scarr, Peter Scheidt, and Susan Spieker.

The National Study of Young Children's Lives

The study that is now in the process of development by the steering committee, with the assistance of its consultant and the co-principal investigators, has been titled "The National Study of Young Children's Lives." It is based on the assumption that the development of infants and toddlers is influenced by a complex interaction between the characteristics of the child and characteristics of the human and physical environment in which the child is reared. Alternate care is construed as part of the physical and human environment in which children of many mothers find themselves. Therefore, characteristics of alternate care are expected to contribute to the overall impact that the environment has on the development of children.

Subjects

The families to be recruited into the study will include those with mothers who, at the time of childbirth, plan to go back to work (or to school) in the child's first year of life, and those who plan to stay home with the child. They will come from different social-economic and racial backgrounds. Both two-parent families and single-parent families will be included. The families will be followed during the target child's first 36 months of life.

The Study blueprint

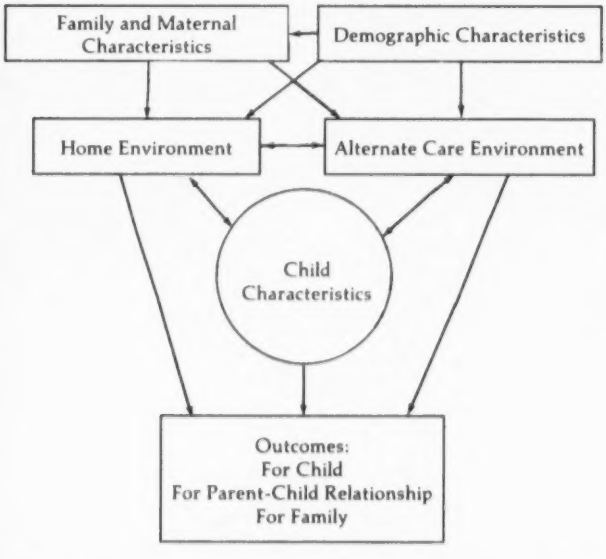
Subject recruitment is expected to start in June 1990. Mothers will be first contacted in the hospital, following delivery. Each family will be visited when the child is 1, 9, 20, and 36 months old. In addition, the family will be contacted by phone every three months. The child will be brought to the laboratory setting at 20 and 36 months and the alternate care situation will be visited when the child is 9, 20, and 36 months. Additional visits in the alternate care situation will take place when the children are either four or 15 months. In five of the sites the alternate care situation will be visited when the children are four months old, and in the other five sites the additional visit to the alternate care will be made when the children are 15 months of age.

The model

Early in the development of the study, the Infant Child Care Network laid out a preliminary model that would guide its selection of research questions and research method.

At the core of the model are the home environment, the alternate care environment, and the infant's characteristics. All these are thought to interact, and to influence the social, emotional and cognitive development of the child. Aspects of the home environment and of the alternate care environment that will be investigated are those pertaining to the amount of the quality of care, as well as to the physical characteristics of the environment. Child characteristics will include the age, sex, health, birth-order and temperament of the child.

Relationships of Interest at Any Given Age and Over Time



The model includes family and maternal characteristics, which are believed to influence the home environment and the choice of the alternate care environment. Family and maternal characteristics that will be studied include the marital status of the mother, the size of the household, mother-partner relationships, stresses and supports, parental attitudes, beliefs and expectations. The model also includes demographic characteristics, such as income, education and race. These are believed to be related to the family characteristics and to the choices regarding alternate care.

All the above components of the model are believed to be related to outcomes for the child, for the relationships between the parents and their children, and for the families involved.

Information that the study will provide

Data from this prospective, longitudinal study will allow the investigators to answer many complex questions concerning child care that are on the minds of parents, psychologists and policy makers. It will do so by providing information about the concurrent and subsequent effects of variations in patterns of early child care on the course of children's socio-emotional and cognitive development over the first three years of life. The study will show how these effects vary as a function of a list of variables, such as characteristics of the child, family and alternate care.

The study will identify the major factors influencing families' utilization of various alternate infant care arrangements. It will also provide information about the ways in which experience in alternate care influences concurrent and/or subsequent features of family environment or family functioning.

Conclusion

The National Study of Young Children's Lives is unprecedented in its size and scope. The collaboration between the National Institute of Child Health and Human Development and leading developmental psychologists across the country in this effort also represents a major innovation in prospective, longitudinal research. The complexity and urgency of the issues before us, and the opportunity to address them, present the NICHD Day Care Research network with an important and exciting challenge.

Opportunities for honors:

The **Maternal and Child Health Section of the American Public Health Association** is soliciting nominations for its Young Professional Award, presented yearly to an individual age 40 or younger who has made a significant contribution to the field of maternal and child health through contributions in administration, advocacy, clinical care, community service, education, and/or research.

Nominations for the 1990 award, which will be announced at APHA's Annual Meeting, must be submitted by May 1, 1990. For information about the award and the selection process, as well as nomination and supporting statement forms, write or call Lorraine V. Klerman, Dr. P.H., Department of Epidemiology and Public Health, Yale School of Medicine, 60 College Street, P.O. Box 3333, New Haven, CT 06510, tel: (203) 785-2885.

The **Literature Prize Committee of the Margaret S. Mahler Psychiatric Research Foundation** is now accepting papers to be considered for the 1990 award of $750 for an original paper dealing with clinical, theoretical or research issues specifically related to Dr. Mahler's concepts of separation-individuation in child development.

Papers must be received by December 31, 1990. Six copies should be submitted for consideration to Marjorie Harley, Ph.D., Chairperson, Margaret S. Mahler Literature Prize Committee, 201 St. Martins Road, Baltimore, MD 21218.

Whole Babies, Parents and Pieces of Funds: Creating Comprehensive Programs for Infants and Toddlers

by
Peggy Daly Pizzo
Senior Program Associate, NCCIP

Every day, providers of early childhood services to infants and toddlers deal with the needs of the whole baby with pieces of funds. Very few whole funding streams are organized so that providers of early childhood services can use one funding stream to serve the whole baby in a family-centered way.

But there are many pieces of federal funding available to support states, local governments and community-based programs striving to provide high quality, comprehensive early childhood services for infants and toddlers. At last count, the General Accounting Office (GAO) enumerated 46 federal programs which provide funds for child care or related services—and the GAO list did not include Medicaid, a funding source which we explore in this article! (General Accounting Office, 1989).

"Piecing together" the funds

To "piece" together the needed funds, early childhood services must learn and use the technical jargon associated with each particular funding stream. An early childhood program which helps low-income families obtain health, educational and social services is, in Medicaid parlance, providing case management services and may be eligible for Medicaid reimbursement for doing so. This same program may also provide developmentally appropriate care that is carefully tailored to all the needs of each baby, including those with developmental delay. In the parlance of early intervention services, this may be a least restrictive environment or a more facilitating environment for infants with special needs. Thus this child care program may be eligible for some reimbursement as an early intervention service under Public Law 99-457.

But in each case, the early childhood services provider must first analyze whether the services they are currently providing or wish to provide are "a good fit" both with the needs of child and family and with the services reimbursable under a particular funding stream. And then the provider must use the technical language of that funding stream, not the language of the early childhood services field, to describe the activities.

By doing so, however, practitioners, administrators and advocates of comprehensive services to disadvantaged children may be able to open up multiple new layers of funds needed to help pay for the caregivers, specialists, health, nutrition, social and educational services and equipment that "whole baby" programs need.

The author wishes to thank Patricia Biro, Ed Cooney, David Chavkin, Libby Grever and Joe Perreault for the information they provided during the development of this article.

Purpose of this article

This article will inform leaders in the early childhood field about the value of the whole baby approach to child care. It will also describe the diverse "pieces" of funds which can be blended together by child care programs (or in some cases, by child care resource and referral agencies) to facilitate the care and education of "whole babies" instead of fragments of the needs of those babies.

The "whole baby" approach to child care

The whole baby approach to child care is one that sees the infant as a human being whose physical, cognitive, emotional and social needs cannot be dealt with as separate domains of development. Multiple and interrelated strands of development combine in the infant and toddler in ways that "blur the lines" between these developmental domains more deeply than is ever experienced again in the lifespan.

Early childhood educators and specialists in infant and child development face the challenge of how to respond to this unique characteristic of infancy with early childhood services that are comprehensive. This means services that do not segregate intellectual stimulation from immunization or promotion of prosocial behavior from protection against accidental injury. It means, for example, services which concentrate on skilled and sensitive nurturing of a somewhat unresponsive baby while also concentrating on correcting the anemia which is making the baby listless.

The family-centered approach to child care

Struggling to meet the needs of the whole baby is one of two central challenges in early childhood services for infants and toddlers. The other challenge is the delivery of the service in a family-centered rather than a provider-centered or even only a child-centered way.

The family-centered approach essentially sees the family as the constant in the child's life, around which the service systems must revolve. It is distinct from the provider or service-system centered approach which sees the services as the center around which the child and family must revolve. It is also distinct from the child-centered approach which may take a profound interest in optimizing the development of the child but very little interest in the developmental challenges and changes, feelings, convictions and level of satisfaction with the services that the parent experiences. (ACCH, 1987; Edge and Pizzo, eds., 1988; Woll and Pizzo, eds., 1988.)

A family-centered approach sees the parents of children as usually the most important persons in a child's life. Services are then structured not just to care for the child in the day to day absence of the parent(s). Family-centered early childhood services strive to motivate and empower the parents to improve the skills they need to be effective and confident nurturers and educators of their own children (if improvement of those skills is needed). In addition, family-centered services strive to motivate and empower parents to be effective advocates for their children's educational,

health, nutritional and social needs (if improvement of advocacy skills is needed).

Five sources of federal funds and the whole baby family-centered approach to child care

With the exception of funds for comprehensive services like the Head Start program and the Comprehensive Child Development Centers (a demonstration program), almost all other federal funds focus on one or at most two objectives related to the child's well-being. Almost none make funds available to foster parent development as well as child development.

However, there are at least five sources of federal funds which can be brought into early childhood and child care programs seeking to become more comprehensive (or into resource and referral agencies which support the development of comprehensive early childhood programs in their communities). These funding sources are described in summary form below.

I. Federal funds for child care under the Family Support Act of 1988

Open-ended federal funds are available for child care for every child eligible for Aid to Families with Dependent Children (AFDC), whose family meets the conditions set forth in the Family Support Act (FSA) of 1988. This new law modifies Title IV-A of the Social Security Act.

Eligibility for FSA funds

These child care funds are available as part of a broader program, whose purpose is to provide incentive and support to AFDC families who participate in employment or training. The part of the FSA which most directly affects infants and toddlers is the requirement that parents between the ages of 16 and 20 who have not yet finished high school participate in full-time educational activities, regardless of the age of their children.

The new law also requires parents of children aged three and up to participate in employment and training as a condition for participation in Aid to Families with Dependent Children. States may impose the identical requirement on AFDC families with children aged 1 to 3, but are not required by federal law to do so. Finally, parents of children of any age may access this federal source of support for child care if they volunteer to participate in employment or training.

These Title IV-A or Family Support Act (FSA) funds can be given to either eligible child care providers or to eligible parents, who then are expected to pay the providers. Unlike Title XX (see below), there is no cap on Title IV-A funds appropriated every year. Thus, the federal government can provide, on an open ended basis, federal matching funds for every eligible child who participates in child care that meets the requirements of state and federal law.

However, like Title XX, these funds will typically be per-child reimbursements for day to day child care services. A limited amount of funds will probably also be made available in each state for resource and referral services designed to assist the parent in locating child care. Reimbursements cannot exceed the market rate in each locality.

FSA funds can be used to provide a wrap-around service to early intervention, family resource and support or Head Start services which are currently part-day. In a wrap-around, these funds are used to lengthen the day or otherwise lengthen the time that the services are available so that the AFDC parents can fulfill the requirements of the Family Support Act.

II. Federal funds for child care under Social Services Block Grant (SSBG) or Title XX

Funding for child care is also authorized under Title XX of the Social Security Act. Title XX is the social services funding stream. Each year a cap on funds for Title XX is appropriated. Within that federal limit, then, states may draw down federal funds to help them provide social services for any family who is currently eligible under both federal and state policy. Usually these are families with very low incomes. One of the social services which the state may elect to fund is child care. (Each state decides how much money it will spend on each of the social services which are eligible for federal matching funds.)

Child care providers typically participate in Title XX by negotiating a purchase of service contract with the state administering agency, by which the state purchases child care "slots" from the provider for a defined number of children eligible for Title XX. Purchase of service funds are usually provided as a reimbursement to the child care provider for a defined amount of time that the child or children have spent in the child care program. Typically, no funds are provided for resource development, that is to create new child care programs.

III. Federal funds related to child care and comprehensive preventive health care (including family support services) under Medicaid

Child care services are typically required by state law to prohibit admittance to the program to any child who has not met age-appropriate immunizations. (There are exceptions in family day care.) In addition, there are often state requirements that children have physical examinations or health assessments in order to safely participate in child care. These are usually considered necessary safeguards to a child's health when being cared for in groups.

However, for low income families in particular, both child care providers and parents are often deeply frustrated by the difficulties parents experience in obtaining these basic health services either prior to entry into child care or throughout the course of the child's participation in child care.

In some states, child care programs, family resource and support programs, Head Start programs and child care resource and referral services which serve Medicaid-eligible families can now apply for and receive Medicaid funds to assist families in gaining access to needed medical, social, education and other services.

In Medicaid terminology, the service of assisting families in this way is called case management services. This is an optional Medicaid service and must be specifically included by the state in its Medicaid plan before case management services can be funded.

New eligibility for Medicaid

Medicaid is authorized under Title XIX of the Social Security Act. It provides open-ended federal matching funds for those eligible services provided to eligible individuals. Historically, the children eligible for Medicaid were typically (although not always) of such low incomes that they participated in the state's Aid to Families with Dependent Children program. Now children of the working poor—the population of children served by child care programs for economically disadvantaged children—are increasingly eligible for Medicaid and, at state option, for case management services.

After April 1, 1990, states must include in Medicaid all pregnant women, infants and children up to age six whose families currently earn less than 133% of the federal poverty line. All of these families are eligible for the full range of preventive health care, for medical treatment and for case management services, if the state has chosen to adopt case management services as one of its options. (Note that this new mandate may make the children of many Head Start and child care providers eligible for Medicaid as well.)

Medicaid and case management services

Early childhood service programs or child care resource and referral agencies which either have developed or have the potential to develop good working relationships with the parents of low-income infants and toddlers are well-situated to provide case management. Good case management requires a long-term commitment to the family and to assisting the family to secure the services that the children and other members of the family need. It also requires a commitment to helping the parent find a "medical home" for the child—a good ongoing source of medical care which can both prevent and treat health problems. Finally, good case management depends on persistence in exchanging and coordinating information among parent, medical home, child care provider and, at times, other health and social service providers.

To become eligible to be reimbursed for case management services, providers of child care, family resource and support, early intervention, Head Start or child care resource and referral services need to take the following steps:

- identify whether at least some of the population served by their program is or will be eligible for Medicaid and whether they need case management services;
- decide what the elements of the case management services to be provided the families will include;
- ascertain whether the state has yet adopted this option in its State Plan;
- discern who is designated by the State Plan as eligible to be reimbursed as a case manager;
- apply for a Medicaid provider number and discuss methods of reimbursement with the state Medicaid agency.

Medicaid and transportation

Child care programs or resource and referral agencies which assist Medicaid-eligible families in gaining access to needed medical services by providing *transportation* to doctor visits, dental appointments and other medical providers can be reimbursed for this service under Medicaid.

Many child care providers and perhaps even resource and referral providers use vans to transport children and caregivers for such child-care related activities as field trips. During the significant periods of non-use, providers can use vans to transport children and parents to health services. This is a natural adjunct of case management services and Medicaid can pay for all or part of the operating costs (including insurance) of the vehicles.

Medicaid and developmental assessment and health education

Finally, under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions of Medicaid, qualified child care programs may also provide developmental assessments and health education for Medicaid-eligible children and be reimbursed by Medicaid for doing so. State law may limit the licensure of individuals qualified to either perform developmental assessments or provide health education to individuals with certain types of degrees. However, child care programs can enter into contractual relationships with qualified individuals (e.g., licensed psychologist) and apply to become an EPSDT provider.

As with case management services, good screening and assessment requires the exchange of information and coordination with a "medical home" for each child. Collaboration with parents is also essential both to obtain input relevant to the assessment and to encourage and support parents in obtaining follow-up remediation of problems detected by the assessment.

IV. Federal funds for child care programs providing nutritious meals and snacks under the Child Care Food Program

Infants and toddlers undergo such rapid physical and mental development that their need for food with appropriate caloric and nutritional content is acute. In addition, mealtimes for infants and toddlers are essential moments in the development of a baby's emotional health and capacity for social interaction. Therefore staff need to have unhurried feeding times with babies and toddlers.

The costs of purchasing, preparing and serving nutritious food to infants and toddlers can be offset by funds from the Child Care Food Program. Authorized under the National School Lunch and Child Nutrition Act, this program is administered at the federal level by the U.S. Department of Agriculture. At the state level, however, it is administered by the

Department of Education, the Department of Human Resources (or Social Services) or the Department of Health.

All children in nonprofit child care centers and sponsored family day care homes are eligible for some type of reimbursement. However,in centers, children in the higher end of the ncome ranges qualify for only a slight reimbursement, while children in the lower income ranges qualify for a more substantial reimbursement. For-profit centers are eligible for participation in CCFP if their total child population is comprised of at least 25% low-income children, currently defined as children participating in Title XX. (Recent legislation authorized a small pilot project to broaden this definition.)

The steps which providers of early childhood services must take to apply for reimbursement differ for centers and for home based programs. Qualifying centers can apply directly to the administering state agency for reimbursement. Family day care homes must work through a nonprofit sponsoring agency, often a center or a resource and referral agency. Since the red tape of applying for reimbursement can be cumbersome to some center providers, some centers are choosing to apply in ways similar to family day care homes, i.e., through an agency that takes responsibility for the paperwork.

V. Federal funds for child care services which provide early intervention services

Family day care homes, child care centers and Head Start programs for infants and toddlers are increasingly asked to enroll infants and toddlers with a variety of special health care needs, developmental delays or atypical patterns of development. This increasing demand is in part due to state efforts to locate children eligible for early intervention services. The demand also reflects parents' need for infant and toddler services which will help them participate in the labor force. Rising medical and other expenses associated with the upbringing of children with special needs propel even more of their parents into the work force—and into the search for child care.

Early intervention services for children under three have been defined in federal law as services "designed to meet a handicapped infant's or toddler's developmental needs in any one or more of the following areas: physical development, cognitive development, language and speech development, psychosocial development or self-help skills." (Education of the Handicapped Act Amendments of 1986.—

Part H of P.L. 99-457, the Education of the Handicapped Act Amendments of 1986, encourages states to identify and provide early intervention services to infants and toddlers who are developmentally delayed or have a physical or mental condition likely to result in developmental delay. (States may also serve infants and toddlers who are "at risk of having substantial developmental delays if services are not provided.") Part H monies are for the planning of services or the expansion of services. States are encouraged to coordinate multiple funding streams; for example, they may use Medicaid to help finance the costs of identifying Medicaid-eligible children through comprehensive health and developmental assessments.

Central to the philosophy and implementation of Part H of P.L. 99-457 is the development of an Individualized Family Service Plan, based on a multidisciplinary assessment of the child and, with the concurrence of the family, a statement of the family's strengths and needs related to enhancing the development of the child. To the extent appropriate, early intervention services must be provided in the types of settings in which infants and toddlers without handicaps participate.

Early childhood programs that wish to become case managers for the infants and toddlers eligible for P.L. 99-457 services may be able to contract with the state to do so. Similarly, those programs that are qualified to provide part of the required multidisciplinary developmental assessment may be able to contract with the state to do so.

It is not clear yet how many states will contract with early childhood programs to provide early intervention services in child care settings. States may be reluctant to use the limited funds appropriated for Part H of P.L. 99-457 to fund the entire costs of an all-day, all-year early childhood program. But they may find it more cost-effective to fund part of the costs of an existing community child care program, and to supply the program with appropriate specialized services and equipment, than to finance start-up costs for new early intervention services.

Elsewhere in this issue of *Zero to Three* (pp. 14-17), innovative efforts to support qualified child care services as early intervention services are described. Child care providers interested in providing early intervention services should contact the lead agency for Part H of P.L. 99-457 in their state and discuss this with agency representatives. They should also try to identify state and local parent advocacy organizations concerned with special needs and make their interest in serving infants and toddlers with special needs known to these organizations. Child care resource and referral agencies can help early childhood program providers connect with the lead agency and with parent advocates for children with special needs—as they can also help parents of infants and toddlers with special needs become aware of their options under P.L. 99-457.

Outlook for the future

The amount of federal financial support for early childhood services is likely to expand substantially over the next few years. Congress will enact child care legislation. Congress will also expand the funds for Head Start. Eligibility for Medicaid and funds for the Child Care Food Program and for P.L. 99-457 may also expand. But the necessity of piecing together funds in order to serve the whole baby and to empower parents will not fade away.

One of the most compelling needs of the 1990s in the field of early childhood services for infants and toddlers is the investment of more funds in all the categories of support mentioned above. But an equally compelling need is the exchange of information, throughout the entire early childhood services delivery system, of creative and workable ways to piece together funding streams. Parents can't be in two different service sites at once. Families don't do well when parents constantly feel torn in two. Furthermore, babies can be damaged by narrowly focused services which ignore, for example, their health needs in order to be exclusively devoted to their cognitive or emotional needs (or vice versa). And once "broken," babies don't get "pieced back together" easily. It's better to piece the funds, provide the support to parents and procure the support we need to help nurture the babies. That's the challenge that faces us now and will continue to face us throughout the coming decade.

Further information on these and other aspects of infant and toddler child care services will be provided at the First National Technical Assistance Conference on Infant Child Care, to be held in the Spring of 1991. This conference will be sponsored in Washington, D.C. by the National Center for Clinical Infant Programs as part of the Better Care for the Babies Project, which is currently supported with funds from the Ford Foundation and the Pittway Corporation. Conference registration and other details will be available soon.

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National Center Notes

by Eleanor S. Szanton

NCCIP is pleased to announce the appointment of two new members to its Board of Directors.

Alicia Lieberman, Ph.D., is Associate Professor of Psychology in the Department of Psychiatry, the University of California at San Francisco. She holds the title of Senior Psychologist at the Infant-Parent Program, San Francisco General Hospital. Dr. Lieberman's work focuses on the integration of theoretical and clinical approaches to infant mental health, with special reference to attachment theory. Dr. Lieberman is a native of Paraguay. Much of her recent research examines mental health and attachment patterns of newly immigrant mothers and babies.

Marilyn M. Segal, Ph.D., is Professor of Developmental Psychology at Nova University in Ft. Lauderdale, Florida. She is Head of the University's Family School Center. She participates in numerous state and community activities, including the Florida State Coordinating Committee for Early Childhood. She is Chair of the A.L. Mailman Family Foundation. Dr. Segal has published numerous books and papers for professionals, for parents, and for policymakers on the growth of typically developing young children and of children with handicapping conditions, most recently *In Time and With Love: A Source Book on Handicapped Infants and Toddlers.*

We welcome Drs. Lieberman and Segal to the Board.

We are also very pleased to announce two recent honors awarded to NCCIP's president, T. Berry Brazelton. It is noteworthy that these honors emphasize Dr. Brazelton's insights into normal child development and his commitment to advocacy on behalf of children, both critical dimensions of our field.

In November 1989, at a symposium in his honor, the Harvard Medical School announced the establishment of the T. Berry Brazelton Chair in Normal Child Development. This is the first chair in a medical school focusing on typical and behavioral aspects of pediatrics.

In January 1990, the Texas Association for Infant Mental Health presented Dr. Brazelton with an award created in his name. Every two years the T. Berry Brazelton Award will be given to an individual who has been an outstanding advocate of infant mental health in Texas.